NO. 43909-3-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

In re the Detention of: E.S.,

Appellant.

RESPONDENT'S BRIEF

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I. INTRODUCTION

E.S. has an unfortunate history of mental illness. In August 2012, while a patient at Western State Hospital (WSH), two of E.S.'s doctors petitioned the Pierce County Superior Court for an order allowing them to continue involuntary mental health treatment for up to an additional 180 days. The commissioner granted the petition, finding E.S. was gravely disabled under the standards established by Washington's involuntary treatment act, Chapter 71.05 RCW.

E.S. now challenges the qualifications of one of the petitioners, as well as the sufficiency of the evidence supporting the trial court's determination that he was gravely disabled. E.S.'s treating psychologist qualified as an examining mental health professional because he was personally familiar with E.S. based on a comprehensive evaluation of E.S.'s mental condition. Substantial evidence, which included testimony from the qualified mental health professional, supports the trial court's findings and its order of commitment should be affirmed.

II. COUNTERSTATEMENT OF THE ISSUES

A. Did E.S.'s Treating Psychologist Qualify As An Examining Mental Health Professional When He Was Personally Familiar With E.S. Based On A Comprehensive Evaluation Of E.S.'s Mental Condition?

B. Did Substantial Evidence Support The Trial Court's Finding That E.S. Continued To Be Gravely Disabled?

III. COUNTERSTATEMENT OF THE FACTS

E.S. has suffered from a mental disorder for several decades. Clerk's Papers (CP) at 83. His first admission to WSH was on October 5, 1978. CP at 83. Since his third admission on September 2, 1988, he has been unable to live outside a hospital setting for any longer than a few months. CP at 83. When discharged from the hospital, E.S. has a pattern of discontinuing prescribed antipsychotic medication, which results in assaultive behavior and an eventual readmission for mental health treatment. CP at 72, Report of Proceedings (RP) at 10-11. On February 12, 2009, he was readmitted to WSH for the 23rd time. CP at 82. Since then, he has continuously resided at the hospital for involuntary treatment of his mental disorder. CP at 82.

E.S.'s February 12, 2009, readmission was precipitated by a criminal charge of fourth degree assault stemming from an incident in which he allegedly followed and assaulted a woman who was walking through a shopping mall. CP at 83. That charge was eventually dismissed without prejudice after the court determined E.S. was incompetent to stand trial. CP at 2-7. E.S. was then transferred to WSH for an evaluation to determine whether a petition for involuntary treatment should be filed. CP at 3.

A petition was filed and granted, and E.S. was subsequently recommitted for successive 180-day periods of involuntary treatment on August 18, 2009, January 21, 2010, May 12, 2010, October 28, 2010, June 9, 2011, and March 5, 2012. CP at 10-12, 25-27, 38-39, 47-49, 58-59, 76-78.

Before the expiration of the March 5, 2012 order, psychiatrist Rolando Pasion, M.D., and psychologist Hamid Nazemi, Ph.D., filed a petition to involuntarily treat E.S. for up to an additional 180 days. CP at 79-92. The doctors stated in their petition that E.S. required additional hospitalization because he continued to be gravely disabled as a result of a mental disorder. CP at 80. Their specific diagnosis was schizoaffective disorder, bipolar type. CP at 91. They based their professional opinion on "observations regarding [E.S.'s] history, condition, behavior and diagnosis," and supported their assessment by extensively citing to historical clinical records and notations in E.S.'s hospital chart in order to fully detail the major ongoing symptoms related to E.S.'s mental disorder. CP at 82-92.

A hearing on the petition was held on August 20, 2012. CP at 94. After E.S. affirmatively stipulated to Dr. Nazemi's qualifications as an

expert in psychology, Dr. Nazemi[1] testified that he was personally familiar with E.S. because E.S. had resided on Dr. Nazemi's assigned ward since March 2012 – six months prior to the petition and hearing. RP at 6. Dr. Nazemi also confirmed that the previous 180-day commitment period gave him an opportunity to observe E.S. on the ward. RP at 7. He further acknowledged that he was familiar with E.S. because he reviewed E.S.'s clinical records and discussed E.S.'s case with other members of the treatment team. RP at 7. While an attempt was made to conduct a separate, formal mental status examination, E.S. was unwilling to cooperate. RP at 7, CP at 86-87.

Dr. Nazemi's testimony then identified E.S.'s current diagnosis of schizoaffective disorder, bipolar type, and described the symptoms E.S. experienced as a result. RP at 6-14. E.S. presents with chronic delusional and grandiose thought processes. RP at 7-8, CP at 88-90. For example, within the most recent period of commitment, he claimed to be an attorney and to have a "Ph.D. as a pathologist." RP at 8, CP at 88-89. He claimed to own property at WSH and demanded that WSH "evacuate the premises." RP at 8, CP at 86. He also insisted he has written famous songs, knows many famous people, and that, as a result, he does not "ever have to work again because [he] ha[s] all this money." RP at 7-8,

[1] E.S. mistakenly refers to Dr. Nazemi as "Dr. Sabeti" on pages 15 and 16 of his opening brief. Brief of Appellant (Br. Appellant) at 15-16.

CP at 89, 85. E.S.'s delusions also manifest as an obsessive preoccupation with his name. RP at 8, CP at 83. He is fixated on the notion that WSH has not correctly recorded his name, and perseverates on this issue to such an extent that it causes emotional lability and interferes with his ability to engage in realistic communications with his treatment team. RP at 8, 13, CP at 85.

E.S. has very limited insight into his mental illness. RP at 8-9, CP at 90. He denies having a mental disorder, and has demonstrated an unwillingness to receive follow-up mental health care should he be discharged from WSH. RP at 9, CP at 90, 85. E.S. spontaneously speaks to himself and occasionally erupts with loud incoherent comments, which suggests he is responding to internal stimuli (i.e., experiencing auditory and/or visual hallucinations). RP at 8, CP at 89. He also requires prompting from hospital staff to complete basic activities of daily living, like showering and changing clothes. RP at 13, CP at 86.

Dr. Nazemi explained that E.S.'s symptoms "directly impact his ability to interact with his environment in a reality-based manner to tend to his basic needs." RP at 13. He further detailed E.S.'s long history of mental illness, including 23 hospitalizations at WSH and the assaultive behavior that results when E.S. stops taking medication. RP at 9-10. Based on all of these factors, Dr. Nazemi opined that E.S. needed

"ongoing monitoring and supervision in the context of a structured hospital setting to ensure his ongoing medication adherence and further improvement." RP at 11. And Dr. Nazemi testified that, if E.S. were to be released, he would be unable to care for his basic needs and would suffer a deterioration in his routine functioning. RP at 10-11.

E.S. was the only other witness to testify at the hearing. RP at 15-20. Before his testimony, E.S. frequently interrupted the proceedings with confusing assertions – mostly claiming his name was John Doe. RP at 4, 11-12. During his testimony, his answers were rambling, disorganized, and unresponsive. RP at 15-20. Most of the statements reflected his perseveration on themes related to his name. RP at 15-20. The commissioner eventually had to interject due to the testimony's "nonresponsive" nature. RP at 19. After E.S.'s counsel replied that she had no further questions, the commissioner confirmed, "I think we're finished at this point" and excused E.S. from the witness stand. RP at 19.

Based on the evidence presented at the hearing, the trial court found that E.S. continued to be gravely disabled under both standards set forth in RCW 71.05.020(17). CP at 96-97. In particular, the trial court found that, as a result of a mental disorder, E.S. was "in danger of serious physical harm resulting from a failure to provide for his . . . essential

human needs of health or safety," and that he "manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his . . . actions and is not receiving such care as is essential for his . . . health or safety." CP at 96. Based on these findings, the trial court ordered E.S. to be involuntarily treated at WSH for up to an additional 180 days. CP at 98. E.S. appealed the order. CP at 99.

IV. ARGUMENT

This Court should not entertain E.S.'s claim for the first time on review that Dr. Nazemi was not a qualified petitioner. Even if this Court does address that argument, the trial court should be affirmed. Dr. Nazemi was a qualified petitioner because he was personally familiar with E.S. based on a comprehensive evaluation of E.S.'s mental condition. Also, substantial evidence supported the trial court's finding that E.S. continued to be gravely disabled.

A. Dr. Nazemi Was Qualified To Petition And Testify In This Case As An Examining Mental Health Professional Because He Was Personally Familiar With E.S. Based On A Comprehensive Evaluation Of E.S.'s Mental Condition

E.S. argues the trial court erred in finding him gravely disabled because the finding was based on a petition and testimony from Dr. Nazemi, who E.S. claims was not an "examining" mental health professional.

However, E.S. did not object to Dr. Nazemi's qualifications to petition for civil commitment, or make any argument regarding the basis for, or sufficiency of, his testimony at the hearing. In fact, E.S. affirmatively stipulated to the doctor's qualifications to testify as an expert witness. RP at 6. This Court should therefore refuse to review E.S.'s claim of error under RAP 2.5(a). *See, e.g., In re Detention of Audett*, 158 Wn.2d 712, 147 P.3d 982 (2006) (in a sexually violent predator (SVP) commitment hearing, defendant failed to preserve his objection to the admission of evidence derived from a mental exam).

Even if this Court chooses to entertain E.S.'s argument for the first time on review, the trial court should be affirmed. Dr. Nazemi was qualified to petition as an examining mental health professional under RCW 71.05.290(2)(b).

A petition for an additional period of involuntary treatment must "summarize the facts which support the need for further confinement" and be supported by an affidavit signed by, *inter alia*, one examining physician and one examining mental health professional. RCW 71.05.290(2)(b).[2] Although the petition and supporting affidavit

[2] The supporting affidavit may also be signed by alternative combinations of physicians, mental health professionals, or nurse practitioners. In full, RCW 71.05.290(2)(a)-(e) permits the affidavit to be signed by: "(a) Two examining physicians; (b) One examining physician and examining mental health professional; (c) Two psychiatric advanced registered nurse practitioners; (d) One psychiatric advanced

must be supported by two professionals, a court may grant the petition after a court hearing in which only one professional testifies. *See, e.g.*, *In re Detention of J.R.*, 80 Wn. App. 947, 950, 912 P.2d 1062 (1996).

In re J.R. is the only case in which Washington courts have directly analyzed the meaning of the term, "examining," in RCW 71.05.290(2). *Id.* at 956. In that case, the court explained that the term, examining, "connotes a continuing process or activity, not one that has a finite beginning and end." *Id.* In light of that construction, a petitioning doctor "who previously has examined a patient, who maintains frequent contact with the patient, and who has extensive current knowledge about the patient's mental status may qualify as an examining doctor and share his information with the court . . . ." *Id.*

A separate, formal mental status examination is not required. *Id.* at 956-57. It is not required because when a patient is being evaluated for an additional 180-day commitment period, "the treating doctor has had a unique opportunity to evaluate the patient . . . ." over the course of the previous 180-day commitment period. *Id.* at 956. That opportunity enables the doctor to become "familiar with the patient by way of ongoing informal examinations . . . ." *Id.* at 957.

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registered nurse practitioner and a mental health professional; or (e) An examining physician and an examining psychiatric advanced registered nurse practitioner." Dr. Pasion was an examining physician and Dr. Nazemi was an examining mental health professional. CP at 81, 92. Only subsection (b) is relevant to this case.

The requirement for an examining petitioner is unsatisfied only if testimony at the commitment hearing establishes that the petitioner "lacks sufficient first-hand familiarity with the patient's mental status to make a diagnosis and recommendation . . . ." *Id.* at 957.

The *J.R.* case involved three consolidated cases in which the patients challenged their 180-day civil commitment, alleging the petitioning doctor was not an examining physician within the meaning of the statute. Applying its definition of the term to the facts of each case, the Court of Appeals held the statute was satisfied in two of the three cases and not satisfied in the other. *Id.* at 957-58.

In the two cases from *J.R.* that satisfied the statute, the Court of Appeals approved of the petitions because the petitioning doctors, as treating physicians, were sufficiently familiar with the patients' mental condition. *Id.* at 950-51. Their familiarity was grounded in their daily proximity to the patients. *Id.* No formal mental status examination was conducted. *Id.* The doctors, instead, relied upon observations during the previous 180-day commitment period, a review of hospital chart notes, and discussions with other members of the treatment team. *Id.*

In the one case from *J.R.* that did not satisfy the statute, the petitioning doctor was not the patient's treating physician and was not adequately familiar with the patient's mental condition. *Id.* at 951-52.

The doctor was merely "covering for another psychiatrist for the two-week period preceding the hearing," and there was no evidence that a separate, formal evaluation was attempted. *Id.* at 952. Nor was there any indication that the doctor had reviewed the patient's historical clinical records or chart notes. *Id.* at 952, 957. Because the doctor had no historical familiarity with the case, evaluated the patient "only cursorily," and "had less than two weeks of contact and the contacts were for very brief periods of time," the Court of Appeals was constrained to uphold the lower court's dismissal. *Id.* at 957.

Dr. Nazemi's evaluation was virtually identical to the evaluations that were approved of in *J.R.* Dr. Nazemi was qualified as an examining mental health professional because he was personally familiar with E.S. In fact, there is no meaningful distinction between the type and extent of information sources used by Dr. Nazemi in this case, and the type and extent of information sources used by the two examining physicians approved of in *J.R.* *Id.* at 950-51, 956-57. In both scenarios, a separate, formal mental status examination was not possible. Yet in both scenarios, the doctors based their opinions on a review of historical clinical records, discussions with the treatment team, and observations on the ward. And in both scenarios, the doctors were able to observe the patient on the ward over the course of the previous 180-day commitment period. This Court

has already established that this level of patient evaluation provides sufficient familiarity for a doctor at WSH to petition for an additional 180-day civil commitment.

This is the most sensible understanding of the term, examining, in RCW 71.05.290(2)(b). Patients are frequently unable or unwilling to participate in a formal mental status examination. Doctors at WSH necessarily form their clinical impressions of a patient based on the comprehensive evaluation that emerges from a myriad of sources. This is as it should be. While first-hand observations are important, they are by no means sufficient. A patient's mental status and condition can often fluctuate from week-to-week or even minute-to-minute. Basing a diagnosis or opinion wholly, or even mostly, on direct patient interactions would be a flawed approach. It is not only acceptable then, it is also appropriate for an examining doctor to rely on other sources of information, like the patient's clinical history,[3] hospital chart notes, and discussion with other treatment team members – a petitioning doctor would not otherwise be wholly familiar with the patient. Dr. Nazemi's

[3] Several statutes directly establish that a patient's historical records are not only relevant, but *especially important* in determining whether civil commitment is necessary. *See*, *e.g.*, RCW 71.05.012 ("For persons with a prior history or pattern of repeated hospitalizations or law enforcement interventions due to decompensation, the consideration of prior mental history is *particularly relevant* in determining whether the person would receive, if released, such care as is essential for his or her health or safety." (emphasis added)); RCW 71.05.285 (in determining whether inpatient or a less restrictive placement is appropriate, "*great weight* shall be given to evidence of a prior history or pattern of decompensation and discontinuation of treatment . . . ." (emphasis added)).

comprehensive evaluation made him personally familiar with E.S. and, thus, qualified him as an examining mental health professional.

The comprehensive evaluation in this case is plainly distinguishable from the unqualified doctor's "cursor[y]" evaluation in *J.R.*, 80 Wn. App. at 957. Dr. Nazemi was E.S.'s treating psychologist for the preceding six months. The unqualified doctor in *J.R.* had been "covering" the ward patients for another psychiatrist for two weeks only. *Id.* at 952. Further, the unqualified doctor's evaluation consisted entirely of "minimal contacts" with the patient over the course of two weeks. *Id.* at 957. There was no indication that the unqualified doctor had ever reviewed the patient's clinical history or chart notes, or discussed the case with other members of the treatment team. *Id.* at 952, 957. There was also no evidence that the unqualified doctor had either attempted or completed a formal evaluation of the patient. *Id.* All of this is in deep contrast to Dr. Nazemi and the two qualified examining physicians in *J.R.*, where six months' worth of personal observations were supplemented with other important information sources to form a comprehensive familiarity with the patient.

Dr. Nazemi was qualified to petition and testify in this case as an examining mental health professional. The trial court correctly relied on

his testimony in determining whether E.S. continued to be gravely disabled.

B. The Trial Court Correctly Found That E.S. Continued To Be Gravely Disabled

The evidence in this case established that E.S. continued to be gravely disabled under both standards provided in RCW 71.05.020(17).

A trial court's findings of fact are not to be disturbed on appeal if supported by substantial evidence. *Davis v. Dep't of Labor & Indus.*, 94 Wn.2d 119, 123, 615 P.2d 1279 (1980). An appellate court will not substitute its judgment for that of the trial court or weigh the evidence or credibility of witnesses. *Id.* at 124. Additionally, where sufficiency of the evidence is challenged, the appellate court should review the facts in the light most favorable to the prevailing party. *Goodman v. Boeing Co.*, 75 Wn. App. 60, 82, 877 P.2d 703 (1994).

Substantial evidence is evidence that would persuade a fair-minded trier of fact of the truth of the declared premise. *Lillig v. Becton-Dickinson*, 105 Wn.2d 653, 658, 717 P.2d 1371 (1986). The standard of proof in a 180-day civil commitment hearing is "clear, cogent, and convincing evidence." RCW 71.05.310.[4] "Clear, cogent, and

[4] RCW 71.05.310 provides that the standard of proof in a 90-day commitment is by clear, cogent, and convincing evidence. Because RCW 71.05.320(6) provides that a 180-day hearing "shall be held as provided in RCW 71.05.310," the standard of proof in a 180-day hearing is by clear, cogent, and convincing evidence as well.

convincing evidence" is evidence that is highly probable. *In re the Detention of LaBelle*, 107 Wn.2d 196, 209, 728 P.2d 138 (1986). Therefore, this Court must decide whether, when viewing the evidence in the light most favorable to the petitioner, the trial court's finding of grave disability was supported by substantial evidence that the trial court could reasonably have found to be highly probable.[5] *Id.*; *see also In re Marriage of Schweitzer*, 132 Wn.2d 318, 329, 937 P.2d 1062 (1997).

Under Washington's involuntary treatment act, Chapter 71.05 RCW, persons may generally be committed for treatment of mental disorders[6] if, as a result of such disorders, they are found to be "gravely disabled" as defined by the act. *See* RCW 71.05.150, .240, .280, .320.[7]

RCW 71.05.020(17) sets forth two alternative definitions of gravely disabled, either of which provides a basis for involuntary

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[5] E.S. makes tangential references to "due process," but without any meaningful development of a constitutional argument. Br. Appellant at 2, 13, 17, 18. This Court should not labor to construe such unsupported allusions as an argument to be addressed. *City of Tacoma v. Price*, 137 Wn. App. 187-88, 200-01, 152 P.3d 357 (2007) (a party raising a constitutional issue on appeal "must present considered arguments . . . naked castings into the constitutional sea are not sufficient to command judicial consideration and discussion" (internal quotations omitted)).

[6] A mental disorder means any organic, mental, or emotional impairment which has substantial adverse effects on the individual's cognitive or volitional functions. RCW 71.05.020(26).

[7] When a person is currently subject to a 180-day order authorizing involuntarily treatment, RCW 71.05.320 specifically authorizes recommitment for an additional 180 days if the person "continues to be gravely disabled." RCW 71.05.320(3)(d), (6).

commitment. *In re the Detention of LaBelle*, 107 Wn.2d 196, 202, 728 P.2d 138 (1986). Specifically, "gravely disabled" is defined as:

> a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

RCW 71.05.020(17). These two alternative prongs of grave disability have been further clarified by the courts.

The Washington State Supreme Court has construed the first definition of gravely disabled, in RCW 71.05.020(17)(a), to require a showing of a substantial risk of danger of serious physical harm resulting from failure to provide for essential health and safety needs. *LaBelle*, 107 Wn.2d at 204. However, it did not require that the substantial risk of harm be evidenced by recent, overt acts. *Id.* Such a requirement has little relevance in circumstances where the risk of danger arises primarily from passive behavior, such as the failure or inability to provide for essential needs. *Id.* The court also rejected the argument that the danger must be imminent, recognizing that the care and treatment received by the detained person in many cases will have lessened or eliminated the imminence of the danger of serious harm caused by a failure to provide for essential needs.

Id. at 203. Requiring "imminent" danger as a prerequisite to continued confinement could result in the premature release of mentally ill patients who are still unable to provide for health and safety needs outside the confines of a hospital setting. *Id.*

The second definition of gravely disabled, contained in RCW 71.05.020(17)(b), was added by the legislature in 1979 with the intention of broadening the scope of the involuntary commitment standards.[8] By incorporating the definition of "decompensation," the progressive deterioration of routine functioning supported by evidence of repeated or escalating loss of cognitive or volitional control of actions, subsection (b) now permits the State to intervene before a mentally ill person's condition reaches crisis proportions. *LaBelle*, 107 Wn.2d at 206. The goal is to break the cycle commonly known as the "revolving door syndrome" where a patient is prematurely released, then decompensates in the community, and is soon re-hospitalized. *Id.* Such intervention is consistent with the express legislative intent that the hospital provide patients with "continuity of care." RCW 71.05.010(4).

[8] Before this section was added, the State could not involuntarily treat those discharged patients who, after a period of time in the community, dropped out of therapy or stopped taking their prescribed medication, exhibiting rapid deterioration in their ability to function independently. *See LaBelle*, 107 Wn.2d at 205. Involuntary treatment was precluded until a person had decompensated to the point that the person was in danger of serious harm from that person's inability to care for his or her needs. *Id.*

Based on the evidence at the hearing, provided by Dr. Nazemi as well as the patient himself, it is clear the trial court had substantial evidence on which to base a finding that it was highly probable E.S. continued to be gravely disabled under either alternative provided by RCW 71.05.020(17).

First, the trial court found by clear, cogent, and convincing evidence that, as a result of his mental disorder, E.S. was "in danger of serious physical harm resulting from a failure to provide for his . . . essential human needs of health and safety." CP at 96. The evidence which supported this finding includes Dr. Nazemi's testimony that E.S. suffers from ongoing delusions regarding his identity, stating at various times he is very wealthy, has written famous songs, knows famous people, is a lawyer, has a Ph.D. as a pathologist, and owns property at WSH on which he plans to evacuate the premises. E.S. also perseverates on the use of his name, which results in argumentative demeanor and emotional lability in general. He responds to internal stimuli by spontaneously talking to himself with loud incoherent comments. He requires occasional prompting with activities of daily living, like showering and changing clothes. And he has very limited insight into his mental illness. Despite these ongoing symptoms, E.S. denies he has a mental illness and has been unwilling to discuss receiving mental health

follow-up care if and when he's transitioned back into the community. Furthermore, E.S.'s demeanor and testimony at the hearing – which was rambling, unresponsive, and perseverative – largely corroborated Dr. Nazemi's assessment. All of these symptoms were informed by E.S.'s long mental health history. This is his 23rd hospitalization at WSH. These hospitalizations have been repeatedly precipitated by E.S.'s assaultive behavior in the community; and the assaultive behavior has been triggered by his failure to comply with prescribed medication.

Viewed in a light most favorable to the State, all of this evidence supports the trial court's finding that it is highly probable E.S. would be unable to provide for his basic health and safety needs. As Dr. Nazemi explained, E.S.'s symptoms "directly impact his ability to interact with his environment in a reality-based manner to tend to his basic needs." RP at 13. The failure to tend to those basic needs – like food, clothing, hygiene, and shelter – would place E.S. in danger of serious physical harm. This finding is all the more substantiated when E.S.'s symptoms are considered in light of his repeated history of medication noncompliance and assaultive behavior outside of the structured hospital setting. Substantial evidence supported the conclusion that E.S. was gravely disabled under RCW 71.05.020(17)(a).

Second, the trial court found that E.S. "manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his . . . actions and is not receiving such care as is essential for his . . . health or safety." CP at 96. The evidence already discussed in support of the trial court's first alternative grave disability finding is equally compelling here. The combination of E.S.'s delusional world view, perseverative behavior, denial of any need for treatment, and extensive history of assaultive behavior while not receiving medication, makes it highly probable that E.S. would suffer severe deterioration in routine functioning based on a loss of cognitive and volitional control. The goal of RCW 71.05.020(17)(b) is to end the cycle of re-hospitalization, the "revolving door syndrome," experienced by patients like E.S. The statute "permits the State to treat involuntarily those discharged patients who, after a period of time in the community, drop out of therapy or stop taking their prescribed medication and exhibit rapid deterioration in their ability to function independently." *LaBelle*, 107 Wn.2d at 206 (internal quotations omitted). This is exactly the case here. The uncontroverted expert opinion in this case was that, if released, E.S. would not receive care essential to his health and safety. Substantial evidence supported the conclusion that E.S. was gravely disabled under RCW 71.05.020(17)(b).

Relatedly, E.S. claims the trial court "did not make independent findings about what evidence it felt proved that E.S. was 'gravely disabled.' " Br. Appellant at 15. This statement ignores the record. A review of the trial court's written findings reveals a detailed catalog of E.S.'s ongoing symptoms, along with a recognition of his long history of prior hospitalizations and assaultive behavior. E.S. seems to argue that the trial court's findings are not independent because a separate, formal mental status examination was not completed and the findings are listed, in part, under a heading titled, "The Respondent's current Mental Status Examination reveals:". CP at 95. This is basically a reiteration of the argument that Dr. Nazemi was not an examining mental health professional. That premise is wrong for the reasons previously discussed. A mental status examination does not mean an isolated, formal examination in this context – it means a comprehensive evaluation by a doctor who is familiar with the patient. In any event, E.S. ignores the fact that the trial court's findings start under that heading but continue into a second heading titled, "And further that the Respondent:". CP at 95. Even if the term, "mental status examination," is so narrowly construed, the trial court's written findings accurately reflect the evidence presented at the hearing.

The trial court should be affirmed.

V. CONCLUSION

This Court should affirm the trial court because substantial evidence, including Dr. Nazemi's testimony, supported the finding that E.S. continues to be gravely disabled.

RESPECTFULLY SUBMITTED this 22nd day of March, 2013.

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CERTIFICATE OF SERVICE

Jeffrey S. Nelson, states and declares as follows:

I am a citizen of the United States of America and over the age of 18 years and I am competent to testify to the matters set forth herein. On March 22, 2013, I served a true and correct copy of this **RESPONDENT'S BRIEF** and this **CERTIFICATE OF SERVICE** on the following parties to this action, as indicated below:

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I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 22d day of March 2013, at Tumwater, Washington.

JEFFREY S. NELSON
Legal Assistant

WASHINGTON STATE ATTORNEY GENERAL

March 22, 2013 - 2:10 PM

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